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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/12/16 through 4/14/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 57 certified bed facility was 45 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 11 and Resident 16) and 5 closed record reviews (Residents 12 through 15 and Resident 17).	F 000	Kissito Healthcare shares the state's focus on the health, safety, and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plant of correction to demonstrate our continuing effort to provide quality care to our residents.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of nursing practice during a medication pass and pour observation that affected 2 of 17 residents (Resident #16 and Resident #17). The findings included: The facility staff failed to follow the five "Rs" (right resident, right medication, right route, right dose, and right time) during a medication pass and pour observation that affected Resident #16 and Resident #17. L.P.N. #2 failed to check the name on the medication label for Resident #16 when Colace was removed from the medication card and administered. L.P.N. #2 administered the	F 281	1. LPN #2 was immediately educated on the 5 R(s) of medication administration. 2. Current residents in the center receiving medications have the potential to be affected. 3. The clinical staff will be educated by the Director of Nursing services/designee on the five R's (right resident, right medication, right route, right dose, and right time) during medication administration. 4. The Director of Nursing Services/designee will observe three nurses weekly during medication observation to ensure the 5 R(s) of medication administration are being completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard D Alba — TITLE: CAO — (X6) DATE: 4/29/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	Continued From page 1	F 281		

Colace from Resident #17's medication card to Resident #16.
The surveyor observed a medication pass and pour observation with licensed practical nurse #2 on 4/12/16 at 4:15 p.m. L.P.N. #2 prepared medications for Resident #16 that included Novolog 4 units subcutaneous, Colace 100 mg (milligrams), Protonix 40 mg, Flaxseed-Fish-Borag 400-400 capsule and Ferrous Sulfate 325 tablet. When L.P.N. #2 looked for the Colace package for Resident #16, L.P.N. #2 was unable to locate the medication with Resident #16's other packaged medications in the top section of the medication cart. L.P.N. #2 checked the bottom drawer and removed Resident #17's medication card for Colace 100 mg capsule. L.P.N. #2 punched one Colace 100 mg capsule out of Resident #17's medication card, placed the Colace with the other medications and administered the medications to Resident #16 at 4:26 p.m. L.P.N. #2 failed to follow the five "Rs" (right medication, right resident, right time, right route, right dose) for medication administration. L.P.N. #2 failed to read the resident's name on the medication card prior to pouring the medication. L.P.N. #2 removed medications from Resident #17's medication card and administered them to Resident #16.
The surveyor reconciled the medications administered with the signed physician orders for Resident #16 and Resident #17. Both residents had Colace 100 mg ordered.
The surveyor interviewed L.P.N. #2 after the medication pass and pour observation on 4/12/16 at 4:50 p.m. The surveyor requested L.P.N. #2 to look at the medication package Colace 100 mg was removed from for Resident #16. The surveyor asked L.P.N. #2 whose name was on

5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

6. Date of Correction-May 28, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	Continued From page 2	F 281		

the package. L.P.N. #2 responded and said "Resident #17." L.P.N. #2 stated when the medication card was removed from the bottom drawer; "I only looked at the name of the medication and not the name of the resident. I didn't pay attention to the name," L.P.N. #2 stated.

The surveyor requested the facility standard of practice for medication administration on 4/13/16 at 9:40 a.m. from the regional nurse consultant. The nurse consultant stated nurses need to do the five "Rs (right resident, right medication, right dose, right route, and right time)" prior to medication administration. The regional nurse consultant stated nurses need to make sure the label on the medication card was for the right resident.

The facility policy titled "General Dose Preparation and Medication Administration" was reviewed 4/13/16. The policy and the facility standard of practice read in part "4. Prior to administration of medication, Facility staff should take all measures required by facility policy and Applicable Law, including, but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Administration Times Schedule."

The surveyor informed the administrative staff of the above finding on 4/13/16 at 3:25 p.m.

Resident #16 was admitted to the facility 3/7/16 with diagnoses that included but not limited to femur fracture, diabetes, heart failure, anemia, hyperlipidemia, cardiac pacemaker, and hypothyroidism. Admission minimum data set (MDS) with an assessment reference date (ARD)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	Continued From page 3 of 3/14/16 assessed Resident #16 with a cognitive summary score of 08 out of 15. Resident #17 was admitted to the facility 7/21/15 and readmitted 10/19/15 with diagnoses that included but not limited to cerebrovascular disease, angina, hypertension, diabetes, iron deficiency anemia, acute kidney failure, and anorexia. Resident #17's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/26/16 assessed the resident with a cognitive summary score of 15 out of 15. No further information was provided prior to the exit conference on 4/14/16.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide the necessary care to attain the highest practicable well-being for 1 of 17 residents (Residents #3). The facility staff failed to assess for pain prior to wound care and failed to stop a treatment and assess Resident #3 for indicators of pain and medicate for pain when it was experienced.	F 309	1. LPN #1 was educated on the center's policy on pain, including assessments for verbal and non verbal residents and how to systematically observe possible pain and comfort thru behaviors/activity change and autonomic responses. 2. Current residents receiving wound care have the potential to be affected.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 4	F 309		

The findings include:

The facility staff failed to assess Resident #3 for pain before a wound treatment, failed to stop the treatment and medicate the resident when the resident screamed and hit staff during the wound care.

The surveyor reviewed Resident #3's clinical record on 4/12/16 and 4/13/16. Resident #3 was admitted to the facility 4/10/15 with diagnoses that included but not limited to unspecified psychosis, hypertension, type 2 diabetes mellitus, major depressive disorder, unspecified dementia without behavioral disturbances, hyperlipidemia, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, hypothyroidism, anorexia, sepsis, and urinary tract infection.

Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/16 assessed the resident with a BIMS (brief interview for mental status) score of 00 out of 15. Section B0700 assessed Resident #3 as making self understood and Section B0800 assessed Resident #3 with the ability to understand others. Section E Behaviors assessed Resident #3 to exhibit physical behavioral symptoms directed toward others1-3 days; verbal behavioral symptoms directed toward others 1-3 days, and other behavioral symptoms not directed at others 1-3 days. Resident #3's presence and frequency of rejection of care was 1-3 days. Resident #3 required extensive assistance of two staff members for bed mobility and was totally dependent on 2 staff members for transfers. Resident #3 required extensive assistance of two staff members for dressing and toileting and was

3. The clinical staff will be educated by the Director of Nursing Services/designee on the center's policy for pain including assessments for verbal and nonverbal residents. The education will include how to systematically observe possible pain and comfort thru behaviors/change in activity and autonomic responses. In addition, education will also include assessing residents who are unable to communicate and undergo a procedure that would be painful for others should be treated for pain preemptively.

4. The Director of Nursing Services/designee will monitor for proper pain assessments during treatment observation three times weekly.

5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

6. Date of Correction-May 28, 2016

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F 309	Continued From page 5	F 309		

totally dependent on 2 staff members for personal hygiene/bathing. Section J0200 Pain assessed that the resident interview should be conducted for pain; however, J0300 assessed that resident scored a "9"-unable to answer and to skip to Section J0800, Indicators of pain or possible pain. J0800 Staff assessment for pain was marked with an "X"-none of these signs observed or documented. Section M0210 Unhealed pressure ulcers coded resident with one (1) Stage 2 ulcer.

On 4/13/16 at 9:56 a.m., the surveyor entered the room of Resident #3 to observe wound care to the Stage 2 left heel decubitus. Licensed practical nurse #1 was assisted by certified nursing assistant #1 during the wound care observation.

The U.S Department of Health and Human Services Treatment of Pressure Ulcers pamphlet defined a Stage II as a pressure ulcer that showed partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shall crater. Pain management and assessment page 31 revealed the following: "Clinicians reported that they observe patients reacting to pressure-ulcer related pain during turning, dressing changes, and debridement. The clinician should recognize that such pain may exist and should assess for its presence. Caregivers should not assume because a patient cannot express or respond to pain that it does not exist. Because pain may be evoked or may be especially acute during dressing changes and debridement, the caregiver should try to prevent such discomfort or take steps to relieve it."

Resident #3 was observed in bed. Certified

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 6	F 309		

nursing assistant #1 stated the dressing to her left heel area had come off earlier that morning.

On 4/13/16 at 10:02 a.m., licensed practical nurse #1 cleaned the over the bed table and placed a clean dry towel on the table. Supplies were placed on the clean towel. L.P.N. #1 washed her hands and applied non-sterile gloves. When L.P.N. #1 moved Resident #3's left leg, Resident #3 screamed "Ow!" Resident #3 yelled when her left knee was extended outward. Neither the licensed practical nurse #1 nor the certified nursing assistant #1asked about her complaints when her left knee was moved. Licensed practical nurse #1 continued to provide wound care to Resident #3. At the point when the cleaning of the wound began, Resident #3 yelled "Go to hell." L.P.N. #1 did not stop the cleaning procedure nor did she ask the resident what the concern was but continued to clean the Stage 2 heel wound. When L.P.N. #1 applied the skin prep to the left heel, Resident #3 was observed to smack the C.N.A. on the left arm. Resident #3 also repeated the phrase "Go to hell!" three more times. L.P.N. #1 continued to pack the wound with a normal saline soaked gauze and apply a border gauze dressing. L.P.N. #1 stated "I'm sorry." Resident #3 screamed at the end of the dressing change. L.P.N. #1 said "I'm sorry" again; however, L.P.N. #1 never asked the resident if she had pain.

Upon completion of the wound care observation, the surveyor asked L.P.N. #1 how she assessed for pain in Resident #3. L.P.N. #1 stated "Anytime you mess with her, she grunts and groans and screams." L.P.N. #1 was asked if the wound care should have been stopped when Resident #3 screamed. She stated "Probably."

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F 309	Continued From page 7	F 309		

L.P.N. #1 stated she would give Resident #3 something for pain.

Licensed practical nurse #2 offered Resident #3 pain medication at 10:15 a.m. Resident #3 refused Tylenol 325 mg (milligrams) for pain.

The surveyor interviewed registered nurse #1 on 4/13/16 at 10:15 a.m. R.N. #1 stated she had known Resident #3 all of her life. "Maybe because she knows me, she doesn't scream out when I do the treatment on her foot. Resident #3 watches me. On occassion, she will scream out when I remove the old dressing but not often."

The surveyor interviewed certified nursing assistant #1 on 4/13/16 at 1:15 p.m. C.N.A. #1 stated Resident #3 screams when there was no care provided. "Sometimes you can hear her scream when you are just walking down the hall and no one is doing anything to her." The surveyor observed certified nursing assistant #1 and certified nursing assistant #2 provide perineal care to Resident #3 on 4/13/16 at 1:20 p.m. When Resident #3's left leg and left knee were moved, Resident #3 screamed. Resident #3 was observed to have contracted legs.

The surveyor reviewed the February 2016, March 2016 and April 2016 progress notes. The notes did not contain documentation of any behavior Resident #3 exhibited during these 3 months. No documentation of screaming or hitting.

The surveyor reviewed the nurse's progress note for 4/13/16 at 1043. The note read in part: "While wound care nurse was attempting wound care to the left heel resident began yelling. This nurse implemented routine standing orders for

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F 309	Continued From page 8	F 309		

Acetaminophen 650 mg (milligrams) q (every) 4 hrs (hours) for pain/fever. Attempted to give resident medication and explained what the medication was and what it was for and resident smacked medications from my hand and began yelling no, no, no. Resident continued to yell after exiting room. _____ [(nurse's signature-LPN #2)]."

The surveyor discussed the issue of medicating a resident who was to receive wound care with the director of nursing on 4/13/16 at 1:30 p.m. The DON stated staff tend to normalize abnormal behavior-example Resident #3's screams. The DON continued to say that Resident #3 screams a lot and staff tend to see that behavior as normal when the screams are abnormal behavior. The DON stated the staff need to figure out what the cause of the screams are.

The resident's current comprehensive care plan dated 2/2/16 was reviewed. The current comprehensive care plan did not include a specific plan of care or interventions when Resident #3 experienced pain. Resident #3's current comprehensive care plan revised 2/2/16 did include the focus area of communication deficit r/t (related to) hearing deficit. Interventions: Monitor/document for physical/non-verbal indicators of discomfort or distress, and follow-up as needed.

Pain assessment as documented on the April 2016 medication administration record from 4/1/16 through 4/12/16 was documented as a "0"-0= no pain. There was no documentation of a pain assessment prior to wound care on 4/13/16 at 9:56 a.m.

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F 309	Continued From page 9 The most recent monthly summary completed 4/6/16 was reviewed for the pain assessment The monthly summary documented Resident #3 had experienced no pain in the past 7 days. The surveyor informed the administrative staff of the above finding on 4/13/16 at 3:25 p.m. The surveyor requested the facility policy on pain management and wound care and Resident #3's pain assessments. The surveyor reviewed the facility policy on pain provided by the regional nurse consultant on 4/13/16 at 2:00 p.m. The policy read "PAIN IN NON-VERBAL RESIDENTS OR THOSE WITH IMPAIRED COMMUNICATIONS" Assessment Strategies: 1. Ask the resident's family or other close caregivers whether or not they think the resident has pain and why. 2. If there is any reason to suspect pain, a diagnostic trial or analgesics is often appropriate. Residents who are unable to communicate and who undergo a procedure that would be painful for others should be treated for pain preemptively. 3. Systematically observe possible pain and comfort behaviors/activity change and autonomic responses. No further information was provided to the surveyor prior to the exit conference on 4/14/16.	F 309		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 10 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to help prevent the development and transmission of disease and infection for 2 of 17 residents (Residents #1 and	F 441	1. RT #1 was educated on the center's policy for trach care including infection control when providing care for the trach. • Resident #9 physician was notified on 4/14/16 of the resident's need to re-culture prior to removing from isolation. • Infections in the center are being tracked and maintained on the infection control log to ensure accuracy and trending of infections. 2. Current residents in the center have the potential to be affected. 3. The clinical staff will be educated by the Director of Nursing Services/designee on protocol for providing trach care including infection control practices. In addition, staff was educated on isolation protocol and procedure for removing residents from isolation. The Director of Nursing was educated by the corporate nurse on tracking and trending of infections in the center, including completion of the infection control log.	

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F 441	Continued From page 11	F 441		

#9); and to maintain an Infection Control Program designed to provide a safe, sanitary, environment.

1. For Resident #1 the facility staff failed to follow infection control practices in trach care.

Resident #1 was admitted to the facility 12/7/15. Diagnoses included, but were not limited to chronic respiratory failure, anemia, hypertension, and Tracheostomy.

The most recent MDS (minimum data set) assessment completed on this resident was a quarterly with an ARD (assessment reference date) of 03/12/16, assessed the resident to understand and to be understood.

On 4/13/16 at approximately 2:30 pm, the surveyor observed tracheostomy care by Respiratory therapist (RT) #1. Respiratory therapist #1 washed her hands with hand sanitizer put her gloves on then proceeded to open the edge of the trach care kit and poured sterile saline into the sterile basin. All this was done on the therapist treatment cart in the hallway. RT #1 then entered the room and placed the trach care kit on to the bed side table (without cleaning the table top). She then removed the dressing from around the stoma and placed in the trash can at the bed side. She then removed her glove on the right hand and placed it in the trash can. Therapist #1 put a sterile glove on her right hand, and then placed the sterile field on Resident #1 ' s chest; Resident #1 reached up with her hand and held it tight in the middle. Therapist #1 then said to Resident #1 don ' t touch it. Leaving the sterile field in place therapist #1 unlocked and removed the

4. The Director of Nursing Services/designee will observe trach care two times per week to ensure infection control protocol is being followed. In addition, residents on isolation will be reviewed during morning meeting to determine the appropriateness of discontinuation of isolation. Infection control log will also be review in the morning meeting to ensure infections are being logged, tracked and determine trending of infections.

5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

6. Date of correction- May 28, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12	F 441		

disposable inner cannula with her non-sterile hand. Then using her sterile gloved hand she placed the new inner cannula into the outer cannula. The therapists then cleaned around the stoma and place a new drain sponge under the tracheostomy tube. Removed her gloves and washed her hands after cleaning up the trash. The surveyor asked the therapist for the facility policy and procedure related to the care she had just provided. RT#1, had difficulty finding the policy so the surveyor asked the director of nurses for it. The policy was located and provided to the surveyor titled Tracheostomy Care without Cuff. It read in part as follows under procedure:
9. Wash hands
10. Put on clean gloves.
11. Remove soiled dressing. Loosen trach tie/holder enough so that you are able to maneuver under trach plate, but not so much that you risk decannulation.
12. Remove gloves; discard in waste and wash hands.
13. Open sterile tracheostomy kit using aseptic technique.
14. Remove sterile drape from trach care kit and spread on bed side table. Do not touch inner sterile field.
15. Empty sterile contents of trach care kit onto sterile drape.
16. Fill one sterile basin with a mixture of sterile water and hydrogen peroxide to make approximately a 50% dilution, and fill another sterile basin with sterile water.
17. Put on sterile gloves. Designate your dominant hand as the sterile hand.
18. If resident has a disposable inner cannula, with non-sterile hand unlock and remove cannula from trach tube and discard in waste bag.
After reading the policy the surveyor spoke with

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13	F 441		

the director of nurses and informed him of the lack of hand washing after removing the soiled dressing and the procedure that RT#1 used as documented above.
The surveyor also informed RT #1 of the lack of hand washing after removing the soiled dressing and the procedure that she used.
On 4/13/16 at 3:30 pm, during a meeting with the administrative staff the above information was shared.
Prior to exit on 4/14/16, no further information was provided to the surveyor related to the infection control issue.
2. Resident #9 was admitted to the facility 3/20/16. Diagnoses included, but were not limited to chronic respiratory failure, anemia, diabetes, thyroid disorder, heart failure, hypertension, and Tracheostomy.

For Resident #9 the facility staff failed to follow the facility policy and procedure for removing the resident from isolation precautions.

The most recent MDS (minimum data set) assessment completed on this resident was an admission with an ARD (assessment reference date) of 04/6/16, assessed the resident to understand and to be understood. Her MDS assessment had her coded for Multidrug-resistant organism (MDRO).

Resident # 9 was care planed for Methicillin Resistant Staphylicoccus Areus (MRSA). One of her interventions she was care planned for was " Follow infection control measures per- facility protocol precautions. "
On 4/12/16 the survey team observed Resident # 9 to be in isolation. The nurse informed the surveyor that Resident #9 was in isolation due to

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14	F 441		

MRSA of her nares.
On 4/14/16 the surveyor was informed Resident #9 had been taken off isolation precautions. A review of the clinical record did not reveal a culture for clearing the resident to come off isolation. The ADON was asked if the resident had been cultured for the MRSA prior to the discontinuation of the isolation. She stated " I didn ' t get an order for the culture because she was treated for 14 days. The isolation policy and procedure (P&P) was requested by the surveyor and reads as follows in part:
Methicillin Resistant Staphylicoccus Areus (MRSA)
10. Discontinuation of isolation precautions: A resident may be considered free of MRSA after two cultures of the colonized or infected body site is negative (except for nares). The first culture should be taken 72 hours or more after antibiotic treatment has been discontinued. The second culture should be taken one week after the first. If the first or the second of these cultures remains positive for MRSA, cultures should continue to be taken one week apart until two consecutive negative cultures have been documented.
A. if a sputum specimen cannot be obtained from a resident who has been colonized/ infected with MRSA in the sputum, the resident ' s throat may be cultured as a surrogate for sputum.
B. if a wound site is healed, the healed site itself may be cultured with a moist swab, according to procedures stated elsewhere in this guideline.
c. When two consecutive negative cultures have been obtained, contact precautions may be discontinued and standard precautions should be followed for the resident.
d. Using cultures of a resident ' s nares as criteria for discontinuing contact precautions is not necessary and should not be done. Negative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15	F 441		

nares culture from a resident does not necessarily provided adequate evidence that the MRSA has been eradicated from that resident. Prevalence surveys have shown that residents may be colonized with MRSA in the absence of infection without the knowledge of the health care staff. Therefore, a resident ' s nares should only be cultured if the resident is implicated in a MRSA outbreak situation and not as a condition for termination of contact precautions.
After reading the policy and the procedure the surveyor asked the director of nurses if the P&P had been followed regarding the removal of Resident # 9 from isolation on 4/14/16 at 10:30am.
He responded " she had MRSA of the nares. After considering what was in the P&P the director of nurses said " I will put her back on isolation today. "
The director of nurse reported back from the surveyor that the physician did not see the need to reculture the resident. "
On 4/14/16 the surveyor spoke with Resident #9 ' s physician informed him the facility had not followed their own P&P in removing the resident from isolation. The physician informed the survey team he would assist the facility where the P&P was concerned.
On 4/14/16 at 12:55 pm, during a meeting with the administrative staff the above information was shared.
Prior to exit on 4/14/16, no further information was provided to the surveyor related to the infection control issue.
3. The facility staff failed to maintain an infection control program to help prevent the development and transmission of disease. The infection log was incomplete from May 2015 through April 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16	F 441		

During the entrance conference, the surveyor requested the facility infection tracking log from May 2015 through present (April 2016). The administrator provided the surveyor with a blank copy of the infection log. The administrator stated the infection control nurse was not at the facility 4/12/16 but would be at the facility 4/13/16. The surveyor was provided the infection log from May 2015 through April 2016 from the infection control nurse (licensed practical nurse #1) on 4/13/16. The surveyor reviewed the infection log and noted the infection control log was lacking components of an infection control tracking program. Components of the infection control program tracking form did not identify any organism if applicable, the source of the infection, the type of isolation, surveillance and monitoring for cross-infections, antibiotic doses and duration, and if the infection had been resolved or was ongoing.

The surveyor discussed the infection log with the infection control nurse L.P.N. #1 on 4/13/16 at 1:45 p.m. L.P.N. #1 stated the facility contracting laboratory does not provide the organism that was cultured. L.P.N. #1 stated the lab provided information if the organism was susceptible or resistive to an antibiotic. "If the resident came from a hospital when admitted, sometimes we get the culture results," L.P.N. #1 stated.

The surveyor informed the administrator, the director of nursing, the assistant director of nursing, the regional nurse consultant, and administrative staff #5 of the above finding on 4/13/16 at 3:25 p.m. and again on 4/14/16 at 12:50 p.m. The surveyor requested the facility policy on infection control.

A review of the facility policy on infection control provided to the surveyor did not include infection tracking information.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 441 Continued From page 17
No further information was provided prior to the exit conference on 4/14/16.

F 502 483.75(j)(1) ADMINISTRATION
SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 17 residents (Resident #2).
The findings included:
The facility staff failed to obtain the physician ordered BMP (basic metabolic panel) for Resident #2.
Resident #2's clinical record was reviewed 4/12/16 and 4/13/16. Resident #2 was admitted to the facility 12/27/14 and readmitted 8/13/15 with diagnoses that included but not limited to dementia with behavioral disturbances, hyperlipidemia, hypertension, constipation, anxiety, and anorexia.
Resident #2's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/5/16 assessed the resident with a summary score of 00 out of 15.
The March 2016 physician orders included laboratory orders to obtain a CBC (complete blood count) and BMP (basic metabolic panel) every 6 months (due March & September).
The surveyor reviewed the laboratory section of the clinical record. In the record, the surveyor located a laboratory result for a CBC and a CMP

F 441

F 502

1. Resident #2's physician was notified on 4/14/16 of lab not obtained for ordered BMP (basic metabolic panel).

2. A review of physician lab orders for the last 30 days will be audited to assure accuracy of physician ordered labs of current residents.

3. The clinical staff will be educated by the Director of Nursing Services/designee on transcription and completion of labs per physician orders.

4. The Director of Nursing Services/designee will monitor lab orders and results five days a week during morning meeting to ensure completion as per physician orders.

5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

6. Date of Correction-May 28, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 18 (complete metabolic panel) obtained 3/3/16. The surveyor was unable to locate the results of the physician ordered BMP for March 2016. The March 2016 progress notes were reviewed. The 3/3/16 08:10 nurse's note read "Note Text: Obtained CBC, CMP from lower left arm. Pressure dressing applied. Resident tolerated well." The surveyor discussed the concern with the director of nursing on 4/13/16 at 1:30 p.m. The DON reviewed the clinical record and stated "The order was transcribed wrong." The surveyor informed the administrator, the director of nursing, the regional nurse consultant, the assistant director of nursing, and administrative staff #5 of the above finding on 4/13/16 at 3:25 p.m. No further information was provided prior to the exit conference on 4/14/16.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	1. Resident #3's and #8's physician was notified on 4/14/16 of omission in medical record of one blood sugar and one dose of insulin. Resident #8 quarterly assessment was completed on 4/14/16 for continued use of the self releasing seatbelt. 2. A review of the medication administration record for current residents in the center with a diagnosis of diabetes for the last 30 days to ensure accu-checks have been competed and documented and ordered insulin as been documented as administered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 19	F 514		

by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 17 residents (Resident #3 and Resident #8).

The findings included:

1. The facility staff failed to maintain complete and accurate April 2016 medication administration records (MARs) for Resident #3. There was no documentation that blood sugar results and insulin administration had been done on 4/11/16 at 5:00 p.m.

The surveyor reviewed Resident #3's clinical record on 4/12/16 and 4/13/16. Resident #3 was admitted to the facility 4/10/15 with diagnoses that included but not limited to unspecified psychosis, hypertension, type 2 diabetes mellitus, major depressive disorder, unspecified dementia without behavioral disturbances, hyperlipidemia, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, hypothyroidism, anorexia, sepsis, and urinary tract infection.

Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/2/16 assessed the resident with a BIMS (brief interview for mental status) score of 00 out of 15. Section B0700 assessed Resident #3 as making self understood and Section B0800 assessed Resident #3 with the ability to understand others. Section E Behaviors assessed Resident #3 to exhibit physical behavioral symptoms directed toward others1-3 days; verbal behavioral symptoms directed toward others 1-3 days, and other behavioral

A review of residents with restraints will be reviewed to ensure quarterly assessments have been completed.

3. The clinical staff will be educated by the Director of Nursing services/designee on documentation of accu-checks and documentation of insulin administration on the medication administration record. In addition, education will also include quarterly assessments for residents with restraints.

4. The Director of Nursing Services/designee will monitor medical records for diabetic residents three times weekly to ensure accu-checks and insulin administration has been documented. In addition, a review of quarterly assessments will be conducted two times a week to ensure timely completion.

5. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

6. Date of Correction-May 28, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 20	F 514		

symptoms not directed at others 1-3 days. Resident #3's presence and frequency of rejection of care was 1-3 days. Resident #3 required extensive assistance of two staff members for bed mobility and was totally dependent on 2 staff members for transfers. Resident #3 required extensive assistance of two staff members for dressing and toileting and was totally dependent on 2 staff members for personal hygiene/bathing. Section J0200 Pain assessed that the resident interview should be conducted for pain; however, J0300 assessed that resident scored a "9"-unable to answer and to skip to Section J0800, Indicators of pain or possible pain. J0800 Staff assessment for pain was marked with an "X"-none of these signs observed or documented. Section M0210 Unhealed pressure ulcers coded resident with one (1) Stage 2 ulcer.

The April 2016 physician orders, reviewed 4/13/16, read in part "Blood Glucose Test Strip (Glucose Blood) 1 device miscellaneous four times a day for DM (diabetes mellitus) and HumaLOG Solution 100 UNIT/ML [milliliter (Insulin Lispro Human) Inject 5 units subcutaneously three times a day for DM (diabetes mellitus)]."

The surveyor reviewed the April 2016 MARs. The entry that read "HumaLOG Solution 100 UNIT/ML [milliliter (Insulin Lispro Human) Inject 5 units subcutaneously three times a day for DM (diabetes mellitus)] Start Date 03/10/16" was blank for 4/11/16 at 5:00 p.m. The paper blood sugar log for April 2016 also had no documentation of the blood sugar result for 4/11/16 at 5:00 p.m.

The surveyor informed the director of nursing on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 21	F 514		

4/13/16 at 9:00 a.m. of the lack of documentation of the blood sugar result and the insulin administration on 4/11/16 at 5:00 p.m. The director of nursing stated that he would contact the nurse assigned to Resident #3 on 4/11/16.

The surveyor interviewed registered nurse #1 on 4/13/16 at 10:15 a.m. R.N. #1 stated she had an orientee with her that day and failed to document both the blood sugar she obtained and the insulin that was administered.

The surveyor reviewed the facility policy titled "Documentation for Point Click Care." Procedure read in part "1. The health record will contain sufficient information to identify the patient; justify diagnoses and treatment; document results of care or treatment; describe the condition of the patient upon discharge; and document instructions to the patient regarding follow-up care, activity levels, and necessary medications."

The surveyor informed the administrative staff of the above finding on 4/13/16 at 3:25 p.m.

No further information was provided prior to the exit conference on 4/14/16.

2. The facility staff failed to document "Pre-Restraining Assessments" done quarterly for Resident #8 and failed to document evidence that Resident #8 was able to release a self-releasing seatbelt.

Resident #8 was originally admitted to the facility 1/3/2013 and readmitted 6/30/15 with diagnoses that included but not limited to type 2 diabetes mellitus, dementia without behavioral disturbances, hypertension, hypothyroidism,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 22	F 514		

gastro-esophageal reflux disease without esophagitis, constipation, and pain.

Resident #8's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/9/16 assessed the resident with a cognitive summary score of 08 out of 15 in Section C. Section B assessed Resident #8 to understand others and to be understood. Section P Restraints had no restraints coded.

The current comprehensive care plan revised 2/18/16 had a focus area that Resident #8 was a fall risk with multiple risk factors r/t (related to) impaired mobility, impaired balance secondary to old stroke, history of falls, impaired decision-making skills r/t dementia, tendency to reach for items off of floor. Interventions: Pad alarm to bed and chair. Monitor functioning qd (every day). Velcro seatbelt when up in GC (gerichair) Date initiated: 01/23/15 and revised 4/12/16.

The April 2016 physician orders read in part "May have alarming Velcro seatbelt d/t (due to) frequent falls while up in chair: Order date 3/18/15 Start Date 4/22/15."

The surveyor observed Resident #8 on 4/14/16 at 12:00 noon. Resident #8 was observed sitting in the day room in a reclined Geri-chair. A seat belt was attached to the Geri-chair. The surveyor spoke with Resident #8 and asked Resident #8 to unfasten the seat belt. Resident #8 was difficult to understand but stated "I can't. I wish I could." Certified nursing assistant #1 was present during the verbal interaction with Resident #8.

The surveyor interviewed licensed practical nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23	F 514		

#3 about assessing the resident for the use of the seatbelt. She stated "I have no reason to ask her to unfasten it."

Resident #8 was able to release the seatbelt when asked by licensed practical nurse #1 on 4/14/16 at 12:58 p.m. However, the surveyor was not present during the observation.

The surveyor interviewed the regional nurse consultant on 4/14/16 at 1:30 p.m. The regional nurse consultant stated nurses should be documenting quarterly assessments for the continued use of the seatbelt. "The seatbelt was intended originally for positioning where Resident #8 slumps and slides out of the Geri-chair. The last assessment was done 9/29/15." The regional nurse consultant stated the staff were not doing the quarterly assessments or documenting when Resident #8 was asked to release the seatbelt on command.

The clinical record revealed Resident #8 had two falls in the last 12 months-one that occurred on 7/23/15 and one on 3/31/16. Both falls were from the resident's bed-not from the Geri-chair.

The surveyor informed the administrative staff of the failure of the facility staff to document the continued need to use the self-releasing seatbelt with Resident #8 on 4/14/16 at 12:50 p.m. and requested the facility policy on restraint usage.

The surveyor reviewed the facility policy titled "Restraint Reduction." The policy read in part "Procedure: 1. Either upon admission to the facility or upon receipt of a restraint order from a physician, the resident Pre-Restraining Assessment will be completed within fourteen

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	495191	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFS OF BASTIAN, INC	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 514	Continued From page 24	F 514		

(14) days by the nursing service professional. 6. Alternatives to the use of the restraint may be used. These will be identified on the care plan."

No further information was provided prior to the exit conference on 4/14/16.